SECTION 9

Medicare Advantage

Chart 9-1. MA plans available to almost all Medicare beneficiaries

	CCPs					
	HMO or local PPO	Regional PPO	Any CCP	PFFS	Any MA plan	Average plan offerings per county
2009	88%	91%	99%	100%	100%	34
2010	91	86	99	100	100	21
2011	92	86	99	63	100	12
2012	93	76	99	60	100	12
2013	95	71	99	59	100	12
2014	95	71	99	53	100	10
2015	95	70	98	47	99	9

Note: MA (Medicare Advantage), CCP (coordinated care plan), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). These data do not include plans that have restricted enrollment or are not paid based on the MA plan bidding process (special needs plans, cost plans, employer-only plans, and certain demonstration plans).

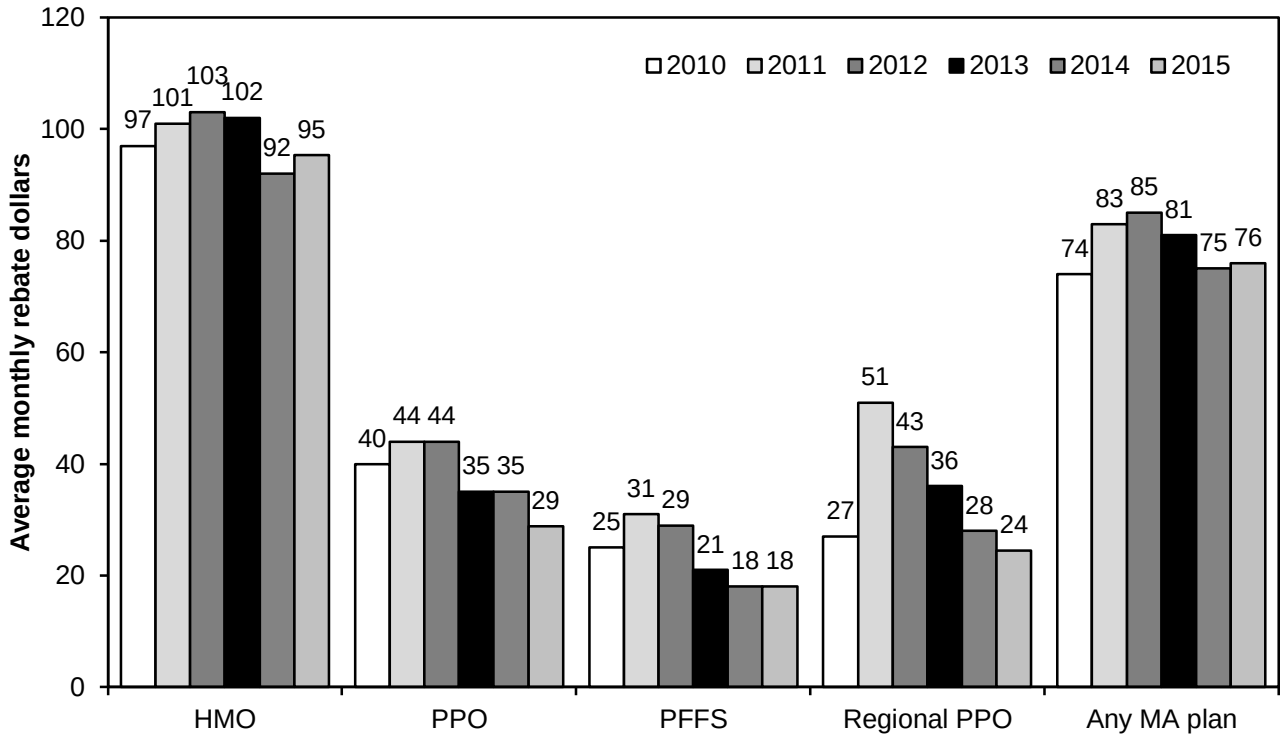
Source: MedPAC analysis of plan bid data from CMS.

- There are four types of plans, three of which are CCPs. Local CCPs include local PPOs and HMOs, which have comprehensive provider networks and limit or discourage use of out-of-network providers. Local CCPs may choose which individual counties to serve. Regional PPOs cover entire state-based regions and have networks that may be looser than those required of local PPOs. Since 2011, PFFS plans (not CCPs) are required to have networks in areas with two or more CCPs. In other areas, PFFS plans are not required to have networks, and enrollees are free to use any Medicare provider.

- Local CCPs are available to 95 percent of Medicare beneficiaries in 2015, and regional PPOs are available to 70 percent of beneficiaries; the availability of both plan types is virtually unchanged from 2013. However, the availability of MA PFFS plans has declined from 59 percent of beneficiaries in 2013 to 47 percent of beneficiaries in 2015. For the past 10 years, almost all Medicare beneficiaries have had MA plans available: 99 percent in 2015, up from 84 percent in 2005 (not shown in table).

- The number of plans from which beneficiaries may choose in 2015 is down from last year. In 2015, beneficiaries can choose from an average of nine plans operating in their counties (this figure is the simple average of plans per county; if counties were enrollee-weighted, the average would be substantially higher). This availability has decreased after peaking in 2008 and 2009, reflecting network requirements for PFFS plans and CMS's 2010 effort to reduce the number of duplicative plans and plans with low enrollment. The decrease in plan choices from 2010 to 2015 was due to the reduction in the number of PFFS and regional PPO plans.

Chart 9-2. Average monthly rebate dollars, by plan type, 2010–2015



Note: HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), MA (Medicare Advantage).

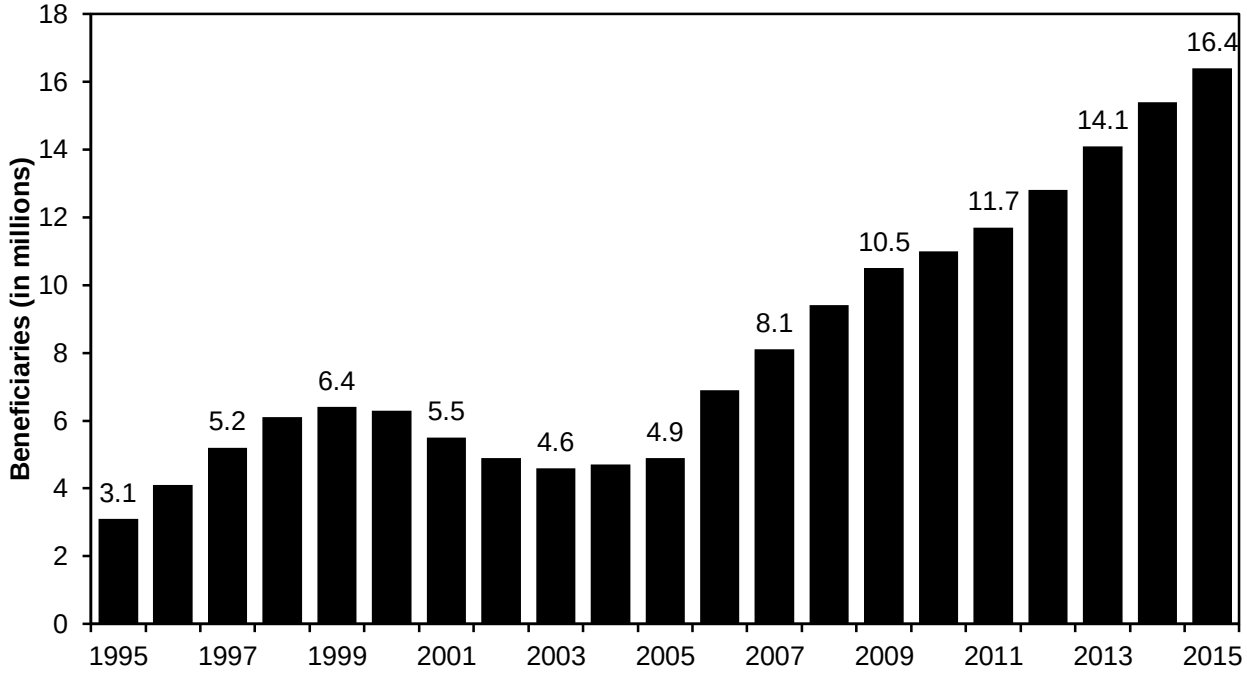
Source: MedPAC analysis of bid and plan finder data from CMS.

- Perhaps the best summary measure of plan generosity is the average rebate, which plans receive to provide additional benefits. Plans are awarded rebates for bidding under their benchmarks. The rebates must be returned to the plan members in the form of extra benefits. The extra benefits may be supplemental benefits, lower cost sharing, or lower premiums.

- HMOs have had, by far, the highest rebates because they tend to bid lower than other types of plans. Average rebates for HMOs have remained relatively stable over this period.

- For the three non-HMO categories, the rebates rose from 2010 to 2011 and declined thereafter.

Chart 9-3. Enrollment in MA plans, 1995–2015



Note: MA (Medicare Advantage).

Source: Medicare managed care contract reports and monthly summary reports, CMS.

- Medicare enrollment in MA plans that are paid on an at-risk capitated basis is at an all-time high, at 16.4 million enrollees (30 percent of all Medicare beneficiaries). Enrollment rose rapidly throughout the 1990s, peaking at 6.4 million enrollees in 1999, but then declined to a low of 4.6 million enrollees in 2003. MA enrollment has increased steadily since 2003.

Chart 9-4. Changes in enrollment vary among major plan types

Plan type	Total enrollees (in thousands) February 2011	February 2012	February 2013	February 2014	February 2015	Percent change 2014–2015
Local CCPs	9,993	11,382	12,580	13,809	14,824	7%
Regional PPOs	1,132	930	1,060	1,221	1,237	1
PFFS	588	518	417	309	260	–16

Note: CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service). Local CCPs include health maintenance organizations and local PPOs.

Source: CMS health plan monthly summary reports.

- Enrollment in local CCPs grew by 7 percent over the past year. Enrollment in regional PPOs grew by 1 percent, while enrollment in PFFS plans continued to decline. Combined enrollment in the three types of plans grew by 6 percent from February 2014 to February 2015.

Chart 9-5. MA and cost plan enrollment by state and type of plan, 2015

State	Medicare eligibles (in thousands)	Distribution (in percent) of enrollees by plan type					
		HMO	Local PPO	Regional PPO	PFFS	Cost	Total
U.S. total	54,156	20%	8%	2%	0%	1%	31%
Alabama	956	16	8	2	0	0	25
Alaska	79	0	0	0	0	0	0
Arizona	1,103	35	3	1	0	0	39
Arkansas	590	8	3	5	4	0	20
California	5,545	38	1	0	0	0	38
Colorado	766	30	3	0	1	3	37
Connecticut	624	22	3	1	0	0	25
Delaware	177	5	3	0	0	0	8
Florida	3,921	28	3	9	0	0	40
Georgia	1,492	9	14	7	1	0	31
Hawaii	240	19	25	1	0	0	46
Idaho	275	17	15	0	0	0	33
Illinois	2,046	8	10	0	0	0	19
Indiana	1,135	3	15	5	0	0	24
Iowa	566	5	8	0	0	2	15
Kansas	482	6	6	0	1	0	14
Kentucky	854	5	14	6	0	0	26
Louisiana	781	26	2	3	0	0	30
Maine	303	14	7	0	1	0	22
Maryland	917	3	2	0	0	4	8
Massachusetts	1,201	15	3	1	0	0	19
Michigan	1,874	13	17	1	0	0	32
Minnesota	898	14	4	0	0	36	54
Mississippi	555	7	3	4	0	0	14
Missouri	1,122	19	6	3	1	0	28
Montana	197	0	16	0	2	0	18
Nebraska	309	6	3	0	2	1	12
Nevada	438	30	4	0	0	0	34
New Hampshire	260	3	2	0	2	0	7
New Jersey	1,478	12	3	0	0	0	15
New Mexico	365	20	11	0	0	0	32
New York	3,308	26	7	3	1	0	37
North Carolina	1,738	13	14	2	1	0	30
North Dakota	117	0	2	0	0	14	16
Ohio	2,126	17	18	3	0	1	38
Oklahoma	670	11	5	1	1	0	17
Oregon	735	26	18	0	0	0	44
Pennsylvania	2,507	25	14	0	0	0	40
Puerto Rico	745	71	4	0	0	0	75
Rhode Island	201	33	1	1	0	0	35
South Carolina	921	7	5	10	1	0	23
South Dakota	154	0	5	0	0	12	18
Tennessee	1,216	24	10	1	0	0	34
Texas	3,565	18	7	4	1	1	31
Utah	337	27	6	0	0	0	34
Vermont	130	0	2	3	2	0	7
Virgin Islands	19	0	0	0	0	0	0
Virginia	1,329	6	4	2	2	2	16
Washington	1,161	25	5	0	0	0	30
Washington, D.C.	87	2	4	0	0	7	13
West Virginia	413	2	20	1	2	2	27
Wisconsin	1,034	18	13	2	1	4	38
Wyoming	94	0	1	0	2	1	3

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Cost plans are not MA plans; they submit cost reports rather than bids to CMS. Component percentages may not sum to totals due to rounding.

Source: CMS enrollment and population data 2015.

Chart 9-6. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2015

	All plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	107%	106%	109%	102%	111%
Bids/FFS	94	90	107	97	108
Payments/FFS	102	101	107	100	111

Note: MA (Medicare Advantage), FFS (fee-for-service), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service).

Source: MedPAC analysis of plan bid data from CMS October 2014.

- Since 2006, plan bids have partly determined the Medicare payments they receive. Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is bid separately). The bid includes plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark.

- The benchmark is an administratively determined bidding target. Legislation established the formula, being phased in by 2017, for calculating benchmarks in each county, based on percentages (ranging from 95 percent to 115 percent) of each county's per capita Medicare spending.

- If a plan's bid is above the benchmark, then the plan receives the benchmark as payment from Medicare, and enrollees have to pay an additional premium that equals the difference. If a plan's bid is below the benchmark, the plan receives its bid plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating and ranges from 50 percent to 70 percent. The plan must then return the rebate to its enrollees in the form of supplemental benefits, lower cost sharing, or lower premiums.

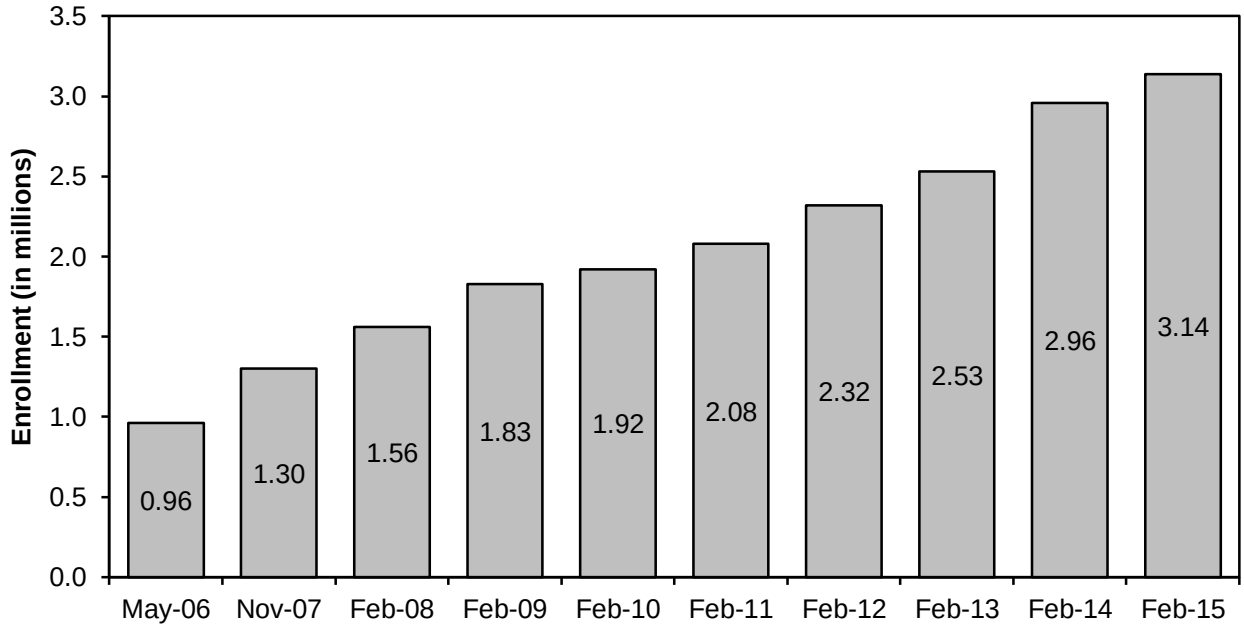
- We estimate that MA benchmarks average 107 percent of FFS spending when weighted by MA enrollment. The ratio varies by plan type because different types of plans tend to draw enrollment from different types of areas.

- Plans' enrollment-weighted bids average 94 percent of FFS spending. We estimate that HMOs bid an average of 90 percent of FFS spending, while bids from other plan types average at least 97 percent of FFS spending. These numbers suggest that HMOs can provide the same services for less than FFS in the areas where they bid, while most other plan types tend to charge more.

- We project that 2015 MA payments will be 102 percent of FFS spending. It is likely this number will decline further over the next two years as benchmarks are reduced relative to FFS levels to complete the transition to the requirements under the Patient Protection and Affordable Care Act of 2010.

- The ratio of payments relative to FFS spending varies by the type of MA plan. HMO and regional PPO payments are estimated to be 101 percent and 100 percent of FFS, respectively, while payments to PFFS and local PPOs average 111 percent and 107 percent of FFS, respectively.

Chart 9-7. Enrollment in employer group MA plans, 2006–2015



Note: MA (Medicare Advantage).

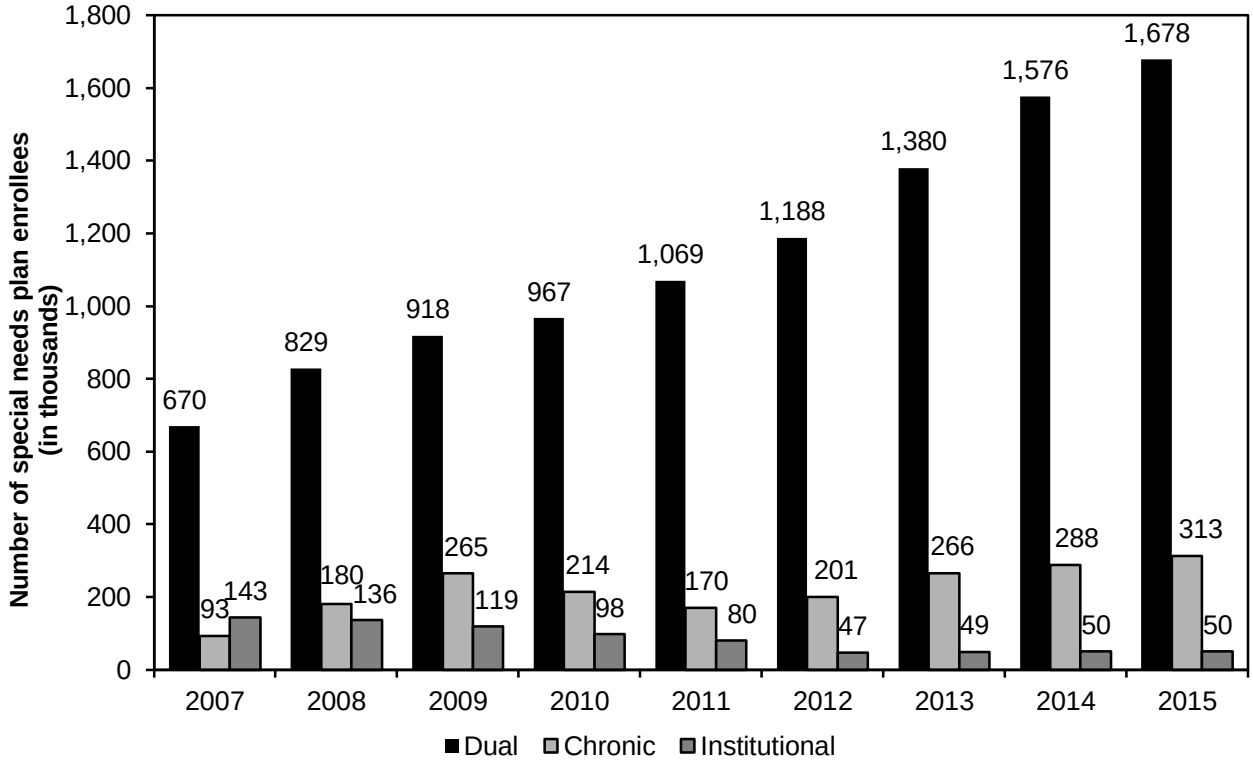
Source: CMS enrollment data.

- While most MA plans are available to any Medicare beneficiary residing in a given area, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions rather than to individual beneficiaries.

- As of February 2015, about 3 million enrollees were in employer group plans, or about 19 percent of all MA enrollees.

- Our analysis of MA bid data shows that employer group plans on average have bids that are higher relative to FFS spending than individual plans, meaning that group plans appear to be less efficient than individual market MA plans. Employer group plans bid an average of 105 percent of FFS, compared with 92 percent of FFS for individual plans (not shown in chart).

Chart 9-8. Number of special needs plan enrollees, 2007–2015



Source: CMS special needs plans comprehensive reports, May 2007, April 2008–2015.

- The Congress created special needs plans (SNPs) as a new Medicare Advantage (MA) plan type in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to provide a common framework for the existing plans serving special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans.

- SNPs were originally authorized for five years. SNP authority was extended several times, often subject to new requirements, most recently in the Medicare Access and CHIP Reauthorization Act of 2015. Absent further congressional action, SNP authority will expire at the end of 2018.

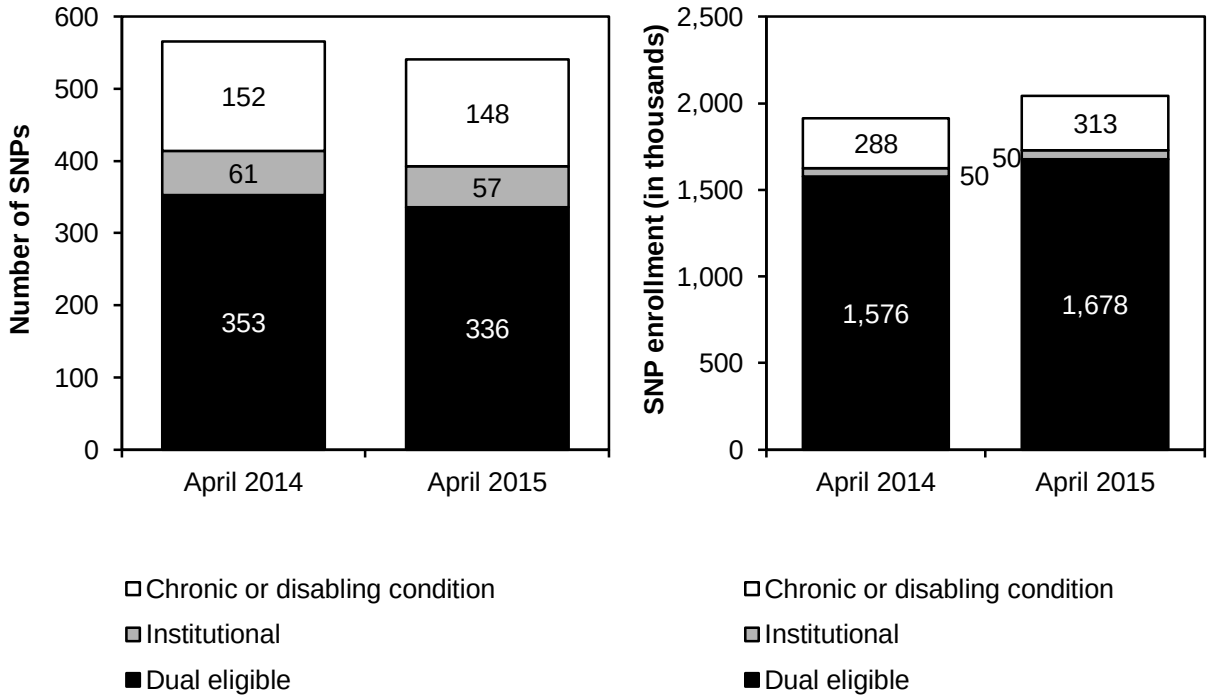
- CMS approves three types of SNPs: dual-eligible SNPs enroll only beneficiaries dually entitled to Medicare and Medicaid, chronic condition SNPs enroll only beneficiaries who have certain chronic or disabling conditions, and institutional SNPs enroll only beneficiaries who reside in institutions or are nursing-home certified.

- Enrollment in dual-eligible SNPs has grown continuously and is about 1.7 million in 2015.

- Enrollment in chronic condition SNPs has fluctuated as plan requirements have changed.

- Enrollment in institutional SNPs declined steadily through 2012 but has held steady over the last couple of years.

Chart 9-9. Number of SNPs declined and SNP enrollment rose from 2014 to 2015



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2014 and 2015.

- The number of SNPs decreased by 4 percent from April 2014 to April 2015, and the number of SNP enrollees increased by 7 percent.
- In 2015, most SNPs (62 percent) are for dual-eligible beneficiaries, while 27 percent are for beneficiaries with chronic conditions, and 11 percent are for beneficiaries who reside in institutions (or reside in the community but have a similar level of need).
- Enrollment in SNPs has grown from 0.9 million in May 2007 (not shown) to 2 million in April 2015.
- The availability of SNPs varies by type of special needs population served (data not shown). In 2015, 82 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (unchanged from 2014), 47 percent live where SNPs serve institutionalized beneficiaries (also unchanged from 2014), and 55 percent live where SNPs serve beneficiaries with chronic conditions (up from 51 percent).

Chart 9-10. Twenty most common condition categories among MA beneficiaries, defined in the CMS–HCC model, 2013

Conditions (defined by HCC)	Percent of beneficiaries with listed condition	Percent of beneficiaries with listed condition and no others
Vascular disease	15.0%	1.6%
Renal failure	14.3	1.5
Diabetes without complications	14.0	5.0
COPD	13.5	1.9
Specified heart arrhythmias	10.9	1.3
CHF	10.8	0.4
Polyneuropathy	10.3	0.6
Major depressive, bipolar, and paranoid disorders	7.6	1.4
Angina pectoris/old myocardial infarction	7.5	0.7
Diabetes with renal or peripheral circulatory manifestation	6.9	0.3
Breast, prostate, colorectal, and other cancers and tumors	6.6	1.8
Rheumatoid arthritis and inflammatory connective tissue disease	5.1	1.0
Diabetes with neurologic or other specified manifestation	4.4	0.5
Cardio-respiratory failure and shock	3.3	0.1
Ischemic or unspecified stroke	2.6	0.2
Seizure disorders and convulsions	2.4	0.3
Major complications of medical care and trauma	2.3	0.2
Drug/alcohol dependence	1.8	0.1
Unstable angina and other acute ischemic heart disease	1.7	0.1
Diabetes with ophthalmologic or unspecified manifestation	1.7	0.5
Vascular disease with complications	1.6	0.1

Note: MA (Medicare Advantage), CMS–HCC (CMS–hierarchical condition category), COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure).

Source: MedPAC analysis of Medicare data files from Acumen LLC.

- CMS uses the CMS–HCC model to risk adjust capitated payments to MA plans so that payments better reflect the clinical needs of MA enrollees given the number and severity of their clinical conditions. The CMS–HCC model uses beneficiaries' conditions, which are collected into HCCs, to adjust the capitated payments.
- CMS is transitioning to a version of the CMS–HCC model that has 79 HCCs, but the year of this analysis is 2013, when the CMS–HCC model included 70 HCCs. The 2013 version had 5 diabetes HCCs, and 4 are among the 20 most common HCCs, including the most common one. Two categories for vascular disease are also among the 20 most common HCCs.

Chart 9-11. Medicare private plan enrollment patterns by age and Medicare–Medicaid dual-eligible status, December 2013

	As percent of Medicare population	Percent of category in FFS	Percent of category in plans
All beneficiaries	**100%**	**72%**	**28%**
Aged (65 or older)	83	71	29
Under 65	17	78	22
Not dual eligible	**82**	**72**	**28**
Aged (65 or older)	73	71	29
Under 65	9	77	23
Dual eligible	**18**	**74**	**26**
Aged (65 or older)	10	70	30
Under 65	8	80	20
Dual-eligible beneficiaries by category (all ages)			
Full dual eligibility	**13**	**81**	**19**
Beneficiaries with partial dual eligibility			
QMB only	2	68	32
SLMB only	2	60	40
QI	1	56	44

Note: FFS (fee-for-service), QMB (qualified Medicare beneficiary), SLMB (specified low-income beneficiary), QI (qualifying individual). "Dual-eligible beneficiaries" are eligible for Medicare and Medicaid. See accompanying text for an explanation of the categories of dual-eligible beneficiaries. Plans include Medicare Advantage plans and cost-reimbursed plans. Data exclude Puerto Rico because of the inability to determine specific dual-eligible categories. As of December 2013, Puerto Rico had 532,000 Medicare Advantage enrollees, which is nearly three-quarters of the Medicare-eligible population. Dual-eligible special needs plans in Puerto Rico had 258,000 enrollees in December 2013.

Source: MedPAC analysis of 2013 denominator file.

- Recent levels of Medicare plan enrollment among the dually eligible represent a significant increase over earlier years. In 2004, only 1 percent of dual-eligible beneficiaries were enrolled in plans, compared with 16 percent of non-dual-eligible beneficiaries.

- A substantial share of dual-eligible beneficiaries (43 percent (not shown in table)) are under the age of 65 and entitled to Medicare on the basis of disability or end-stage renal disease. Beneficiaries under age 65 were less likely than aged beneficiaries to enroll in Medicare plans in 2013 (22 percent vs. 29 percent).

- Dual-eligible beneficiaries who have full dual eligibility—that is, those who have coverage for their Medicare out-of-pocket costs (premiums and cost sharing) as well as coverage for services such as long-term care services and supports—are less likely to enroll in Medicare plans than beneficiaries with "partial" dual eligibility. Full dual-eligibility categories consist of beneficiaries with coverage through state Medicaid programs that include drug coverage, as well as certain QMBs and SLMBs who also have Medicaid coverage for services. The latter two categories are referred to as QMB Plus and SLMB Plus beneficiaries. Beneficiaries with partial dual eligibility have coverage for Medicare premiums (through the QI or SLMB program) or Medicare cost sharing in addition to premiums, in the case of the QMB program. SLMB-only and QI beneficiaries have higher rates of plan enrollment (40 percent and 44 percent, respectively) than any other category shown in this chart, and the rates are higher than the average rate (28 percent) across all Medicare beneficiaries in 2013.

Chart 9-12. Distribution of MA plans and enrollment by CMS overall star ratings, March 2015

Plans and enrollment	Year 2015 star ratings: Number of stars							
	5	4.5	4	3.5	3	2.5	2	Any star rating
All plan types								
Number of plans	11	61	86	136	73	26	1	394
As share of rated plans	10%	21%	35%	23%	10%	2%	<1%	100%
HMOs								
Number of plans	11	44	60	84	58	17	1	275
As share of HMO enrollees	14%	20%	29%	24%	11%	1%	<1%	100%
Local PPOs								
Number of plans	0	17	23	44	10	8	0	102
As share of local PPO enrollees	N/A	32%	47%	17%	1%	3%	N/A	100%
Regional PPOs								
Number of plans	0	0	1	5	3	1	0	10
As share of regional PPO enrollees	N/A	N/A	40%	28%	26%	6%	N/A	100%
PFFS								
Number of plans	0	0	2	3	2	0	0	7
As share of PFFS enrollees	N/A	N/A	66%	26%	8%	N/A	N/A	100%

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), N/A (not applicable), PFFS (private fee-for-service). For purposes of this table, a "plan" is an MA contract, which can consist of several options with different benefit packages that are also referred to as plans. Cost-reimbursed HMO plans are included in the data. Numbers may not sum to 100 percent due to rounding; enrollment totals are rounded results of the sum of unrounded numbers. In 2015, star ratings ranged from 2.0 to the maximum 5.0 (the highest possible star rating).

Source: MedPAC analysis of CMS star ratings and enrollment data 2015.

- The star rating system is a composite measure of clinical processes and outcomes, patient experience measures, and measures of a plan's administrative performance. The overall star rating includes performance on Part C measures and Part D measures.

- The average overall star rating across all plans is 3.64, or 3.96 on an enrollment-weighted basis. There are 151 plans, with nearly 500,000 enrollees, that do not have a star rating because they are too new to be rated or there is insufficient information on which to base a rating.

(Chart continued next page)

Chart 9-12. Distribution of MA plans and enrollment by CMS overall star ratings, March 2015 (continued)

- Under the statutory provisions that introduced quality bonus payments in 2012, plans with ratings of 4 stars or more receive bonus payments in the form of an increase in their benchmarks. Plan star ratings also determine the level of rebate dollars, with higher rated plans able to use a higher proportion of the difference between the plan bid and benchmark amounts to provide extra benefits to enrollees.

- Plans with a 5-star rating are able to enroll beneficiaries outside of the annual election period, on a year-round basis. The 5-star status of such plans is highlighted in the Medicare.gov website's Medicare Plan Finder.

- HMOs are the only plan type for which there are 5-star plans. Nine MA HMO plans and two cost-reimbursed HMO plans have 5-star ratings. The highest star rating attained by any local PPO is 4.5, whereas the highest rating for a regional PPO or PFFS plan is 4. The majority of enrollees in regional PPO plans are in plans with a star rating below 4 stars.

- Plans with ratings below 3 stars have an indicator of their status in the Medicare Plan Finder. CMS has the authority to terminate plans that have had three consecutive years of poor performance (a star rating below 3 stars) in either their MA or Part D performance.

- The criteria for determining plan star ratings change from year to year. Therefore, plan ratings across years are not entirely comparable. Beginning in 2012, a weighting approach was used that assigns greater weight to outcome measures and patient experience measures, with less weight assigned to process and administrative measures. In 2015, a little over two-thirds of the weight of measures reflects Part C and Part D clinical quality measures, compared with 62 percent in 2012 and 49 percent in 2011.